



**BlueCross
BlueShield**

Federal Employee Program

BESREMI

PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn: Clinical Services
Fax: **1-877-378-4727**

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)				Provider Information (required)		
Date:				Provider Name:		
Patient Name:				Specialty:		NPI:
Date of Birth:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female			Office Phone:		Office Fax:
Street Address:				Office Street Address:		
City:	State:	Zip:		City:	State:	Zip:
Patient ID:	R <input type="text"/>			Physician Signature:		
PHYSICIAN COMPLETES						

Besremi

(ropeginterferon alfa-2b-njft)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its entirety for processing

Is this request for brand or generic? ☐ Brand ☐ Generic

How many syringes will the patient need for an 84 day supply? _____ syringe(s) per 84 days

1. What is the patient's diagnosis?

☐ Polycythemia vera

☐ Other diagnosis (*please specify*): _____

2. Does the prescriber agree to monitor the patient's CBC as indicated during therapy? ☐ Yes ☐ No

3. Does the prescriber agree to monitor for **ALL** of the following: neuropsychiatric disorders, autoimmune disorders, ischemic disorders, and infectious disorders? ☐ Yes ☐ No

4. Is there an existence of, or history of severe psychiatric disorders, particularly severe depression, suicidal ideation, or suicide attempt? ☐ Yes ☐ No

5. Does the patient have moderate or severe hepatic impairment (Child-Pugh Class B or C)? ☐ Yes ☐ No

6. Does the patient have a history or presence of active serious or untreated autoimmune disease? ☐ Yes ☐ No

7. Is the patient an immunosuppressed transplant recipient? ☐ Yes ☐ No

8. Has the patient been on Besremi continuously for the last **6 months**, excluding samples? *Please select answer below:*

☐ **NO** – this is **INITIATION** of therapy, please answer the following question(s):

a. **FEMALE Patient:** Is the patient of reproductive potential? ☐ Yes* ☐ No

**If YES, please answer the following questions:*

i. Will the patient complete a pregnancy test before starting treatment with Besremi? ☐ Yes ☐ No

ii. Will the patient be advised to use effective contraception during treatment with Besremi and for eight weeks after the final dose? ☐ Yes ☐ No

☐ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:

a. Has the patient had an improvement in hematological parameters such as hematocrit, platelets, or leukocytes? ☐ Yes ☐ No

b. **FEMALE Patient:** Is the patient of reproductive potential? ☐ Yes* ☐ No

**If YES, will the patient be advised to use effective contraception during treatment with Besremi and for eight weeks after the final dose? ☐ Yes ☐ No*



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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 minutes FASTEST AND EASIEST	Now you can get responses to drug Prior Authorization requests securely online. Online submissions may receive instant responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to Caremark.com/ePA .
Phone (4-5 minutes for response)	The FEP Clinical Call Center can be reached at (877)-727-3784 between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 days for response)	Fax the attached form to (877)-378-4727 . Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. <u>Please only fax the completed form once as duplicate submissions may delay processing times.</u>

faster... easier... better...	Introducing ePA! Online Prior Authorizations in minutes through Caremark.com/ePA . Sign up today!
	CVS/caremark 